**Appendix 2**

**Naso-Gastric Tube (NGT) pH Testing and Documentation**

Name :

Date of birth:

Hospital Number:

Ward:

|  |  |  |
| --- | --- | --- |
| **Date &Time**  | **Actions, Decisions and Outcome** | **Signature** |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Date**  |  |  |  |  |  |  |  |  |  |  |  |
| **Time** |  |  |  |  |  |  |  |  |  |  |  |
| Check that measurement at nostril correlates with above measurement | **Tick** |  |  |  |  |  |  |  |  |  |  |  |
| Aspirate tube with 60 ml syringe | **Tick** |  |  |  |  |  |  |  |  |  |  |  |
| Check pH of aspirate using CE branded strips**DO NOT USE NGT if PH** **is > 5.0** | **pH:****-----** | **pH:****-----** | **pH:****-----** | **pH:****-----** | **pH:****-----** | **pH:****-----** | **pH:****-----** | **pH:****-----** | **pH:****------** | **pH:****-----** | **pH:****-----** | **pH:****-----** |
| If unable to obtain aspirate or pH is >5.0 refer to Decision Tree or refer to medical staff. Document actions | **Tick** |  |  |  |  |  |  |  |  |  |  |  |
| **Initials** |  |  |  |  |  |  |  |  |  |  |  |  |

* Requirement for NGT discussed with medical team and deemed necessary
* Discussed with patient/parent/guardian and verbal consent obtained
* Dietician aware of placement if feeding is indicated
* Duodernum applied to protect skin form abrasion from adhesive dressing

Signature-------------------------------Name-----------------------------Date---------------------

Insertion date------------------Insertion Time--------------------Tube size-------------------------------

Measured Length (cm)-------------- Secured at (cm)----------------- Initial Gastric pH---------------